MENTAL HEALTH AND COUNSELING OF THE ELDERLY DURING THE COVID-19 PANDEMIC

A Thesis

Presented to the

Faculty of the College of Graduate Studies and Research

Angelo State University

In Partial Fulfillment of the

Requirements for the Degree

MASTER OF SCIENCE

by

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May 2021

Major: Counseling Psychology

MENTAL HEALTH AND COUNSELING OF THE ELDERLY DURING THE COVID-19 PANDEMIC

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DEDICATION

I would like to dedicate this thesis to all those who have been with me throughout the thesis process. First, I want to thank my parents. My mom and dad have always gone above and beyond for me in my life, and my thesis is no exception. All the days spent helping me edit and catch my writing mistakes have not gone unnoticed. My parents have instilled in me a strong sense of importance in education and perseverance. I always have felt love from both of them, even when we may have minor arguments. They let me live in their house for the entire time I was writing this thesis, which takes a lot of love. Without their help and love, this thesis would not have been finished. I love you both.

I also want to thank the rest of my family for dealing with me throughout this process. Sometimes I was not around while chapters needed to be written, but my family was always supportive and told me to keep going. My family always let me know how much they cared for me and my success. The calls asking for my progress, and the constant "reminders" are prime examples. Thank you, Nana, Pa, Mooma, Poopha, Cheryl, Chad, Kami, Jay, Lillie, Danley, and Hudson.

I also want to send thanks to Mrs. Nichols, my third-grade teacher. I have not been in her classroom for some time, but without her, I would have never gotten to where I am academically. Before her class, I hated school and my grades showed it. I acted out and my parents did not know what to do. Mrs. Nichols taught me the joys of school and set me on the right path.

Finally, I want to thank my beautiful significant other, Betty. She was there physically and emotionally throughout writing this thesis. Her unquestionable love and support throughout the thesis writing process were felt and helped me through the process. I love you, Betty.

ACKNOWLEDGMENTS

I would like to acknowledge my thesis chair Dr. Singg. Dr. Singg has helped me during every step of the thesis process, on top of performing her many duties for so many others. Dr. Singg is a busy woman, but she always had time to help me finish this thesis. She also had a lot of patience for my questions and writing difficulties. From my time as her graduate assistant to her being my thesis chair, she has provided significant help in my academic goals.

I would also like to acknowledge the Graduate Thesis Coordinator for Angelo State University, Angela Allen. Through the proposal and final thesis process, she was always available for questions. She always got back to me quickly, and would always answer my questions while also doing so for the rest of the thesis students.

Finally, I wish to acknowledge the remaining members of my thesis committee, Dr. Kelley, Dr. Choi, and Dr. Wright. Each member of my committee was helpful and understanding during the thesis process. They each provided insightful comments on my thesis chapters, while also performing their regular duties at ASU. Dr. Kelley was more than willing to stay after class to answer questions I had about my thesis in person. Dr. Choi was always quick to send corrections back, which was always helpful. Finally, Dr. Wright was perhaps an even better employer than he was a committee member.

ABSTRACT

COVID-19 has been a changing force in many people's lives since it began spreading in March 2020. One group that has been hit hard by the virus is the elderly. The difficulties this group is facing are contributing to negative mental health outcomes. For this reason, action must be taken. This thesis explored some pertinent areas of research regarding elders and COVID-19. These areas included age discrimination, social isolation, and death anxiety. A scientifically based treatment plan for the elderly during COVID-19 and similar pandemics was also proposed.

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CHAPTER I

INTRODUCTION

COVID-19, or the coronavirus, changed people's lives this last year, but one group hit harder than others is the elderly. At the time of writing, the Centers for Disease Control and Prevention [CDC] website shows that of all the deaths associated with COVID-19 in the United States, 81.2% were 65 or older despite only making up 14.3% of total cases (2021). While most of the world focused on the medical implications this had on senior citizens, many researchers are focusing on the psychological impact of the virus on this population. However, one area that lacked attention is the development of a counseling protocol for elderly patients dealing with pandemics such as COVID-19.

Research related to COVID-19 and the elderly is growing, and most of this research is divided into three common topics: age discrimination, social isolation, and death anxiety. Age discrimination refers to discrimination based on a person's age, which was a widespread problem before the outbreak. In 2003, Dittmann reported that 80% of senior citizens reported experiencing age discrimination. Malik (2020) conducted empirical research proposing evidence that during the pandemic, age discrimination is thriving and worsening. Social distancing for the elderly left many clients in a state of social isolation that caused or worsened mental health problems (Tyrrell & Williams, 2020), such as depression and suicidality (Jawaid, 2020). Death anxiety, or fear of death, is used in COVID-19 literature to refer to the phenomenon of exacerbated distress related to aging and mortality coming from the disease's effects on the elderly (Ishikawa, 2020). COVID-19 brought death anxiety to

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much more elderly than younger individuals (Ishikawa, 2020). The term death anxiety, which will be explained later in this manuscript, will encompass the terms fear of death, fear of dying, and end-of-life anxiety in the present thesis.

Rationale for Research

As of writing this manuscript, the CDC (2021) continues to urge the use of masks and social distancing measures, and these world-renowned scientists warned the public of a more infectious strain of COVID-19 in the United States. The news headlines show that the vaccine will not be available to the wider public until the summer of 2021, and the fall or winter for children 16 years or younger (Schreiber, 2020). Also, there are doubts that people will take it in mass numbers due to mistrust of the vaccine (Paulsen, 2020). Even when a vaccine is available, certain quarantine procedures will have to remain longer to protect the elderly and other at-risk populations. Therefore, counselors and other mental health practitioners require a mental health treatment protocol for the elderly impacted by the COVID-19 before more harm can befall this population.

The issues senior citizens are facing during the pandemic are not new, so it is expected that this research will remain useful even after the pandemic ends. Age discrimination existed well before COVID-19, but a virus that disproportionally affects the elderly brought these beliefs to the forefront of conversations. Elderly isolation has been a topic of research for years, but a pandemic that forced many to stay at home or be secluded in nursing homes worsened this issue. COVID-19 did not create a fear of dying in the elderly, but perhaps made it worse. Research into these topics and treatment for these conditions,

even when looked at through the lens of COVID-19, can easily be modified to fit the treatment of the elderly after the pandemic is over or if a new such crisis arises.

To date, a comprehensive treatment plan for elderly adults that considers the growing body of scholarly literature written about COVID-19 has not been created. Papers and articles that independently study COVID-19 make suggestions for treatment based on their findings. However, no one combined the information into an organized single source. Given the dire situation that COVID-19 continues to affect the elderly population across the world disproportionally, it is necessary and important to combine the large body of literature to fully understand the impact and create an implementable treatment protocol.

Procedure and Organization of Thesis

The research will be conducted using the online databases available through Angelo State University's Porter Henderson Library. PsycINFO, PsycARTICLES, Academic Search Complete, and SAGE Journals Online will be the main databases included in the literature search. Keywords used will include COVID-19, coronavirus, elderly, counseling techniques for the elderly, isolation, teletherapy, therapy, nursing home, anticipatory grief, ageism, age discrimination, social distance, and family involvement. Interlibrary loans will be used to obtain articles that may be unavailable digitally through Angelo State University's database subscriptions. After finding all pertinent information, a treatment protocol will be developed using the information found in the literature. The criteria for the inclusion of suggestions from the literature in the treatment protocol are as follows:

- The study must be peer-reviewed.

- The study must be done within the year 2020 if the study is discussing COVID-19, but information about treatment protocol before the pandemic may be dated before 2020.
- The study must be specifically targeting elderly participants.
- The study must be an original study or report original research.

The examination of the pertinent literature will be integrated and organized into the following additional chapters. Chapter two will discuss COVID-19, in general, to better understand the virus, its effects on the human body, and why it is more dangerous for elders than other parts of the population. Chapters three, four, and five will discuss in depth the common issues discussed in the recent research on COVID-19 and the elders: age discrimination, social isolation, and death anxiety. Each of these chapters will elaborate on the terms used, discuss how prevalent these issues are in the elderly population, and discuss the research findings and conclusions. Chapter six will discuss how therapists are counseling clients despite COVID-19, what changes are being made in counseling protocols because of COVID-19, what changes are working and are not working, and the best safety techniques being used for elderly clients. Chapter seven will combine all information found throughout the thesis to create a counseling protocol for elderly clients during the COVID-19 pandemic. Finally, chapter eight will provide a summary of this thesis.

CHAPTER II

ORIGIN, NATURE, AND EPIDEMIOLOGY OF COVID-19

Chapter two focuses on COVID-19. Before discussing the complex problems the virus causes, it is important to give a good empirically supported explanation of the virus itself. This is especially important because of the amount of false information released about COVID-19 since March 2020. This chapter will discuss definitions of COVID-19, theories of the virus's origin, how the virus is transmitted, the risk factors of severe symptoms, the range of symptoms people have experienced when infected with COVID-19, and why elders are significantly more at risk than the rest of the population.

First, it is important to define the term COVID-19. Anthony Fauci, Chief Medical Advisor to the President, described COVID-19 back in March 2020 as a new coronavirus respiratory disease that had not been previously identified (2020). The CDC (2021) now describes COVID-19 as a novel coronavirus different from earlier strains of the same coronavirus. These two definitions are similar; however, they indicate we know more about COVID-19 now than a year ago.

The most up-to-date theory as to the origin of COVID-19 was found in the Journal of Advanced Research (Shereen, Khan, Kazmi, Bashir, & Siddique, 2020). The researchers have posited that, like most new diseases, COVID-19 mutated from an earlier strain of the virus in animals (Shereen et al., 2020). The virus was transmitted to many different animals, but the bat was the animal that is believed to have transmitted the disease to humans (Shereen et al., 2020). The next phase of the origin of COVID-19 has the least amount of information. Shereen identified different theories about COVID-19 jumping from bats to humans; people

consuming bats as food, direct contact between bats and humans, or an intermediate host (Shereen et al., 2020). This happened first in the city of Wuhan, China, and the disease began to spread.

The CDC (2021) states that COVID-19 most commonly spreads among people who are in close contact with one another. COVID-19 is a respiratory disease, so it travels through droplets in an infected individual's cough or sneeze, and when the person exhales, talks, or sings too close to another person. Researchers for the CDC have realized these droplets can travel farther than 6 feet. They have also found that community spread, where a disease is spread between people from the same community rather than from people outside of the community, is a significant problem, which is the primary reason that masks are being highly suggested (CDC, 2021).

The CDC (2020) suggests risks associated with "severe symptoms" that may not bear contagion. These risk factors are not contributing to an increase in the likelihood of catching COVID-19 but to experience "severe symptoms." COVID-19 is a dangerous virus, according to experts like Fauci, but some people experience deadly symptoms while others experience little to no symptoms (Fauci, Lane, & Redfield, 2020). Risk factors include cancer, kidney disease, down syndrome, obesity, among others. The full list on the CDC website is updated regularly when additional evidence is obtained.

COVID-19 affects people differently, with a wide range of symptoms being displayed. One of the most difficult aspects of this disease is that people can be asymptomatic, where they experience no symptoms with no indication they are infected with the virus (Colandrea, Gilardi, Travaini, Fracassi, & Funicelli, 2020). Researchers are still

unsure as to date what determines if a person is asymptomatic (Colandrea et al., 2020). Most symptomatic cases of coronavirus are mild-to-moderate cases, with the following symptoms; low-grade fever, cough, fatigue, loss of taste and smell, among others (Christiano, 2020). Mild to moderate cases are distinct from more severe ones because of a lack of bodily impairment, and the disease feels more like a cold (Christiano, 2020). The severe symptoms of COVID-19 include mild and moderate symptoms, as well as shortness of breath, chest discomfort, confusion, trouble staying awake, eye problems, and a blueish face/lips (Christiano, 2020). Doctors state that trouble breathing, including significant shortness of breath, is always a medical emergency, and COVID-19's attack of the respiratory symptoms in some people is extremely deadly leaving lasting damage on those that survive the disease (Christiano, 2020).

Mueller, McNamara, and Sinclair (2020) have done extensive research into elders and COVID-19, with one question being "why age matters when it comes to COVID-19" (p. 9959). The team recognized that one reason is that the aged population is more likely to have many of the risk factor conditions associated with severe symptoms of COVID-19 (Mueller et al., 2020). However, they determined that this is only part of the story, with the rest of the reason being related to human genetics. As humans age, our cells naturally change in ways that encourage diseases and disorders that younger populations rarely see (Mueller et al., 2020). According to the team, these changes primarily come from the passage of time, but they discuss possible biochemical therapies in the future able to alter a person's cells to appear younger (Mueller et al., 2020). The other major factor contributing to the different mortality rates between the elderly and other age groups, according to some researcher's

opinions, is the medical field's inherent bias, prioritizing younger patients over older ones (Ishikawa, 2020).

The information gained from the research about COVID-19 makes it clearer that a counseling protocol for the elderly during the pandemic is needed. COVID-19 is not going away anytime soon (Castro, Ares, Cuesta, & Manrubia, 2020). For counselors working with the elderly, they cannot afford to wait until the disease passes.

CHAPTER III

AGE DISCRIMINATION

Chapter three focuses on age discrimination. Age discrimination can be a foreign topic to some, and confusing to others. Definitions, prevalence, medical and psychological effects, and suggestions to fix the problem of age discrimination are discussed below.

The literature on age discrimination primarily uses four terms to describe roughly the same phenomenon: age discrimination, ageism, age bias, and age stereotyping. These terms are so similar that this thesis will use only the term age discrimination from this point forward for simplicity. The term age discrimination can be described in many ways, so it is important to define this term based on the literature. The oldest definition goes back to 1969 with Butler, who introduced the term "ageism" to encourage social reform on what was becoming a growing issue in healthcare (Wilson et al., 2017). He defined the term as "systematic stereotyping or discrimination against people because they are old." Of course, over the years, more definitions have developed. Stone and McMinn (2012) define age discrimination as "bias against older people by the (temporarily) young." Another definition calls it simply "age discrimination," which implies discrimination based upon a person's age, either young or old (Dittmann, 2003). However, the definitions being used for this thesis comes from the 2009 article, "A Conceptual Analysis of Ageism," which, after exploring multiple definitions of age discrimination, defined the term as "negative or positive stereotypes, prejudice and/or discrimination against (or to the benefit of) aging people because of their chronological age" (Iversen, Larsen, & Solem, 2009, p.4). It should be noted that some researchers disagree with the simplicity of the definition being used in this thesis,

and prefer a more specific definition (Haidt, & Jussim, 2016; Lilienfeld, 2019; Lilienfeld, 2016). These researchers point out the disputed research on certain types of discrimination, and would prefer to distinguish between normal, nonharmful discrimination that human brains die to categorize things and significant, harmful, unjust discrimination (Haidt, & Jussim, 2016; Lilienfeld, 2019; Lilienfeld, 2016).

Before diving into the research done on age discrimination, it is important to discuss how common this phenomenon is for the elderly. If age discrimination is not common, it could be less useful to research the topic than something more common. However, sadly, age discrimination is common. Age discrimination was a widespread problem before the outbreak of COVID-19, with 80% of senior citizens in 2003 having reported experiencing one or more forms of age discrimination (Dittmann, 2003). More recently, researchers in 2015 combined multiple studies showing a strong positive correlation between a higher percentage of older people in the population of a country and negative elder attitudes among youth (North & Fiske, 2015). They specifically mentioned that this correlation is only true in more western, developed nations with less collectivist cultures (North & Fiske, 2015). According to Malik (2020), during the COVID-19 pandemic, age discrimination is thriving and worsening. He found that the biggest provider of anti-elderly sentiments is on social media (Malik, 2020). He found one-fourth of a sample of 18,128 tweets consisting of harmful languages, like derogatory terms or wishes for death, directed towards the elderly (Malik, 2020). This survey was done in March 2020, with earlier studies done before COVID-19 finding less anti-elderly language (Malik, 2020). Malik concluded that the increase can be attributed to COVID-19 and how it affects young and old people differently.

Also, new hashtags like “OK, Boomer” and “Boomer Remover” that contain significant anti-elder language have seen increased usage during COVID-19 (Meisner, 2020). To be fair, research also found some areas where age discrimination is not as common as expected. When focusing on doctors in the medical field, researchers found it difficult to determine age discrimination frequency, measuring this phenomenon by giving practicing doctors surveys looking to find instances of preferring young over young patients or holding ageist beliefs (Wilson et al., 2017). They hypothesized doctors would score statistically significantly higher than the general populous on a test of age discrimination in the workplace (Wilson et al., 2017). However, their findings stated that age discrimination is not inherently more or less likely in medical professionals (Wilson et al., 2017). The researchers concluded that, in reality, most age discrimination in doctors comes from their work environments and upbringings instead of their medical education (Wilson et al., 2017).

Research shows many negative effects of age discrimination on senior citizens. Age discrimination is positively associated with anxiety and health worries in the elderly population (Bergman, Cohen-Fridel, Shrira, Bodner, & Palgi, 2020). Age discrimination is also negatively associated with loss of feelings of “mattering,” a term used to determine life worth, which affects loneliness and physical health (Flett & Heisel, 2020). Ayalon (2020) determined that the anti-elder language is contributing to intergenerational tension. Intergenerational tension results in increased physical and emotional attacks on the elderly (Ayalon, 2020). Ayalon (2020) explains the reason this violence is against the elderly more than against the young is because of the inherent differences in the two groups’ development, as well as different levels of stress felt by the age groups being under quarantine measures.

When looking through training material in the nursing field, Stone and McMinn (2012) found an extensive amount of anti-elder language. Monahan, Macdonald, Lytle, Apriceno, and Levy (2020) have done work compiling evidence of both "positive" and "negative" age discrimination during the pandemic and the effects both have had on older adults. Examples of "negative" age discrimination were views against this age group online and the instinct for caregivers to "overcare" for elderly clients due to them being "fragile" (Monahan et al., 2020). They found that "negative" age discrimination had harmful impacts on the elderly population, including perpetuating negative stereotypes of the elderly, increased social isolation, and loss of economic stability (Monahan et al., 2020). An example of "positive" age discrimination sighted was the creation of elder-only shopping times along with other elder privileges created during COVID-19 (Monahan et al., 2020). The problem is that the examples of "positive" age discrimination resulted in the same negative psychological impacts as the examples of "negative" age discrimination (Monahan et al., 2020). Finally, researchers found that elders have suffered the most from social distancing requirements, which the authors equate to age discrimination (Tyrrell & Williams, 2020). These researchers found elders experiencing the highest rate of family violence, domestic violence, and social isolation (Tyrrell & Williams, 2020).

While researchers look into many different aspects of age discrimination, most of these studies have shown similar conclusions. Stone and McMinn (2012) suggest for those working with elders to make sure the language they are using is not anti-elderly by bringing their awareness to common age discrimination words and phrases, especially when working with this population. Ayalon (2020) concluded the primary issue is portraying all older adults

as one large homogenous group when discussing them. Malik (2020) admitted that the problem of elder abuse and age discrimination is difficult to combat. Still, that psychoeducation targeting common elder stereotyping, as well as intergenerational contact, was found to have the largest effect. He also suggested increasing funding to Adult Protective Services (APS) as the agency is under-funded (Malik, 2020). Meisner (2020) also highlights the importance of advocacy and increasing awareness of this problem. Monahan et al. (2020) push for policy changes in health care, education, and employment to curb age discrimination quickly. Another conclusion made by researchers is that it is important to factor in geography and multiculturalism when discussing age discrimination since culture plays a large role in some people's opinion of the elderly (North & Fiske, 2015). Researchers concluded the increased role of ageist stances in the western world, for example, to highlight during the COVID-19 pandemic specifically (Bergman et al., 2020). Another suggestion made by researchers is to help elders by targeting them with counseling interventions highlighting their self-worth and mattering, two concepts often harmed by age discrimination (Flett & Heisel, 2020). Following the suggestion of these researchers, developing the counseling protocol is one goal of the present thesis.

The information gained from the research on age discrimination makes it clearer that a counseling protocol for the elderly during the pandemic is needed. This chapter has shown that age discrimination has worsened because of COVID-19, and the effects of age discrimination are harmful. Counselors need the tools to deal with this problem now.

CHAPTER IV

SOCIAL ISOLATION OF ELDERLY

Chapter four will focus on another major research area related to COVID-19 and the social isolation in the elderly population. Social isolation is a topic that appears to be widely known but not widely understood. Because of this, exploration of the empirical research related to the topic is important. Thus, definitions, prevalence, medical and psychological effects, and suggestions to fix the problem of social isolation are discussed below.

Research on social isolation has been around for years and has proven to be a hot topic with COVID-19. Although the effects of social isolation on every age group have been studied, the focus of this thesis is the effects on the elderly. When discussing social isolation, a major issue researchers came across while defining the term was to explain the difference between social isolation and loneliness. Social isolation, as described by specific researchers, is the act of being separated from social contacts, either physically or mentally, while loneliness is the subjective feeling of being socially isolated (Tyrrell & Williams, 2020). Another way to describe loneliness, which is found in most research on the topic, is the discrepancy between desired and perceived social relationships (Palgi et al., 2020). For example, social isolation might involve being forced to stay in a house without going outside, while loneliness would involve the effect of staying in that house on a person's mental health. Therefore, while most research on this topic discusses how COVID-19 forced social isolation on elders, the researchers are often studying and collecting data on loneliness, the

outcome of social isolation. Another way to explain this is that loneliness is widely a psychological phenomenon, while social isolation is a term used by more disciplines (Tyrrell & Williams, 2020). Since mental health is the focus of this thesis, loneliness caused by social isolation is the focus of this chapter, rather than social isolation alone.

The accurate prevalence of social isolation and loneliness in the elderly can be difficult to assess. The research shows that loneliness and social isolation were an enormous problem even before COVID-19. One study in 2011 found 24% of individuals 65 years or older were socially isolated, with the socially isolated group consistently being lonelier than those not socially isolated (Cudjoe, 2020). Loneliness was measured through a scale asking questions related to loneliness made by the researchers that they determined was valid and reliable (Cudjoe, 2020). Another study in 2012 used a similar method to Cudjoe (2020) and found 43% of people over the age of 60 experienced loneliness at least sometimes (Luchetti et al., 2020). Finally, in 2018, 35% of people over the age of 45 in a nationwide survey, conducted by the United States federal government, self-reported feeling lonely (Luchetti et al., 2020). Although the rates of loneliness and social isolation were high before COVID-19, they have increased during the pandemic. Tyrrell and Williams (2020) state plainly that COVID-19 caused a “pervasive impact of increased loneliness and social isolation” (p. 215). Tyrrell and Williams (2020) support this conclusion by pointing to how elderly individuals are separated from family members, friends, caregivers, and other social resources while being under quarantine. The elders belonging to other vulnerable groups such as veterans are even more at risk of experiencing social isolation and loneliness (Marini, Pless Kaiser, Smith, & Fiori, 2020).

Other researchers found that stay-at-home orders have caused elders not to leave their homes and often not be able to contact the outside world (Shuja, Shahidullah, Aqeel, Khan, & Abbas, 2020). Physical contact is clearly difficult for elderly people in quarantine, but many elderly individuals do not have access to the technology necessary for virtual contact (Shuja et al., 2020). Using this logic, these researchers claim that since there is a rapid increase in social isolation, there is a rapid increase in loneliness (Shuja et al., 2020). However, some evidence is not so clear-cut. Another group of researchers found that social distancing does not affect every elderly person in the same way (Palgi et al., 2020). Some can be resilient to the feeling of loneliness social distancing can bring (Palgi et al., 2020). These researchers found that while the number of people qualifying as socially isolated increased, the rate of people claiming loneliness did not increase as dramatically (Palgi et al., 2020). Specifically, the researchers found that just in their sample 634 of the 1059 participants became qualified as social isolated by being required to quarantine due to contracting COVID-19, but comparing the loneliness of the socially isolated sample from the non-social isolated sample revealed no significant differences in the two groups (Palgi et al., 2020). They did find that being socially isolated increased the likelihood of having severe psychiatric problems associated with social isolation (Palgi et al., 2020). They conclude that although loneliness is still increasing because of COVID-19, some elderly people can cope better than others because they possess greater coping skills and support systems (Palgi et al., 2020).

Several psychiatric symptoms have been associated with social isolation and loneliness on the elderly population are reported in the literature. According to Tyrrell and

Williams (2020), loneliness is a risk factor for depression, anxiety, suicide, cardiovascular disease, and cancer, among other things. Jawaid (2020) found the same risk factors of social isolation and said many of these risk factors increase an elder's susceptibility to COVID-19. One doctor working with elders in long-term care stated, "these people are like prisoners in the one-room homes, isolated from each other and the outside world." (Eghtesadi, 2020, p. 949). Tyrrell and Williams stated that a "salient risk factor for loneliness is age," explaining this is due to an increased likelihood of losing friends and family as time goes on (p.214).

Besides loneliness, social isolation has other side effects. The primary problem that arises from being forced to stay indoors is a lack of exercise. One group of researchers focused on how social distancing measures can lead to a dramatic loss of physical activity for the elderly since they do not leave their houses as often (Roschel, Artioli, & Gualano, 2020). This group clarifies that physical inactivity caused the deaths of millions of people each year, especially those 65 years or older, because of fragility, sarcopenia, or other chronic diseases (Roschel et al., 2020).

The consensus of the research is that social isolation, through various risk factors, leads to higher mortality rates in multiple separate samples (Tyrrell & Williams, 2020). Some authors have suggested how to combat social isolation and loneliness. One researcher suggests elders could be put on a call list manned by volunteers who would talk to them to help maintain a semblance of a connection with others (Jawaid, 2020). This idea proposed by Jawaid has been tested by a separate group, who set up a call list for the same reason (van Dyck, Wilkins, Ouellet, Ouellet, & Conroy, 2020). This group, who made no mention of Jawaid in their article, reported less loneliness experienced by elders in the program (van

Dyck et al., 2020). Roschel et al. (2020), the group that focused on physical inactivity from social distancing, suggested that policymakers and medical personnel prescribe resistance exercises as “medicine” to their older clients. Other researchers encouraged safe social interactions with proper safety measures in place, like masks and social distancing to safely get elders out of their houses (Palgi et al., 2020). However, the most common suggestion was to use technology like virtual communications. One group stated video conferencing should be utilized for teletherapy and virtual communication to help elders maintain social contact during COVID-19 by allowing them to communicate with their counselors and loved ones (Marini et al., 2020) Eghtesadi (2020) suggested the same as Marini et al. but also added the importance of providing tech support to elders that have difficulty using certain technology. Eghtesadi (2020) also suggested that nursing homes and other long-term care facilities need more funding to pay for facility improvements to help curb social isolation, such as increased access to technology and expanded facilities.

The above information gained from the research about social isolation and loneliness makes it clearer that a counseling protocol for the elderly during the pandemic is needed. This chapter has shown that social distancing has become social isolation for some during COVID-19. Counselors will benefit from empirical-based strategies to deal with this problem.

CHAPTER V

DEATH ANXIETY

Chapter five focuses on death anxiety. Death anxiety can be a dark or difficult topic to approach for some. Definitions, prevalence, medical and psychological effects, and suggestions to fix the problem of death anxiety are discussed below.

Feifel (1956) was the first to use the term death anxiety, defining the phenomenon as "when a person views death as the end and not the beginning of a new life" (pg. 130). Since then, death anxiety has been heavily researched, with multiple definitions being used to describe the concept. One definition is that death anxiety is persistent, an abnormal fear of dying (Rababa, Hayajneh, & Bani-Issa, 2021). Another is that death anxiety is intense anxiety and distress caused by the awareness of mortality (Ring, Greenblatt-Kimron, & Palgi, 2020). In the literature, most researchers agree that death anxiety related to COVID-19 is also largely influenced by health worries, and some researchers include health worries in their definition of death anxiety (Ring et al., 2020). Health worries are thoughts and images that have negative psychological effects without the ability to control them (Ring et al., 2020). With all this being said, for the present thesis, the definition of death anxiety used will be a fear response to the awareness of impending death (Ishikawa, 2020). The response can include mourning death, panicking about death, planning for death out of fear, or psychological reorganization to cope with death (Ishikawa, 2020). Finally, death can be real or perceived for a person suffering from death anxiety. (Ishikawa, 2020).

Researchers have expressed serious concerns about death anxiety among elderly individuals. Worcester (2020) makes an important point that even if the pandemic was not

happening, some elders would still experience death anxiety. People are wrestling with their mortality for reasons unrelated to COVID-19, but the pandemic and the restrictions it created have only made these numbers worse (Worcester, 2020). An experiment involving 904 quarantined individuals compared the quarantined population to the general population in Portugal (Ferreira, Pereira, da Fé Brás, & Ilchuk, 2021). The study found that those in quarantine had higher anxiety, as 37.1 percent of the sample reported a problem related to loneliness compared to the national average of 11 percent, including death anxiety, and higher health-related quality of life problems (HRQoLs) than the general population (Ferreira et al., 2021). They also found that those with higher anxiety had higher HRQoLs. Further, they found elderly individuals over 65 had the highest anxiety levels out of all age groups in the study (Ferreira et al., 2021). According to Ring et al. (2020), since elders are at a higher risk of having a significant adverse effect when infected with the virus, they naturally are the largest group of people with an increase of death anxiety. Rababa et al. (2021) added another dimension to this phenomenon by saying that COVID-19 has forced many elderly individuals to face their mortality before they were ready. However, it is important to point out that some research has reported mixed findings showing that some elders can be very resilient to death anxiety. For example, Wilson, Lee, and Shook (2020) reported that older adults are, overall, less susceptible to the increase in death anxiety from COVID-19 than younger individuals. The positive association between death anxiety and perceived likelihood of contracting COVID-19 is significant for those at age 18-49 years old but not for those 50+ years (Wilson et al., 2020). However, the earlier research found that older adults experience more overt death anxiety, but younger individuals experience more covert death anxiety (Galt &

Hayslip, 1998). In conclusion, even though some elders have adapted well from COVID-19 and the restrictions it has caused, others have seen a sudden onset of death anxiety (Ishikawa, 2020).

Experiencing death anxiety has many adverse effects on a person's well-being (Rababa et al., 2021). Ring et al. (2020) discussed this theoretically using Terror Management Theory (TMT). According to Ring et al. (2020), humans can avoid confronting their mortality by developing unconscious protective mechanisms. An example of such a mechanism is remembering how far away death is when a person is young (Ring et al., 2020). Because of these mechanisms, theoretically, a person cannot directly confront their mortality, which is good because if any person would be completely subjected directly to their mortality, they would experience unbearable distress (Ring et al., 2020). Ring et al. (2020) explain that as people age, their protective mechanisms begin failing, and elders naturally begin experiencing higher death anxiety because of this. Death anxiety is associated with decreases in physical functions, psychological stress, weakening religious beliefs, life dissatisfaction, and poor resilience (Rababa et al., 2021). Researchers have also found that excessive death anxiety harmed people's psychological well-being and personal self-image (Barnett, Anderson, & Marsden, 2018). Finally, increased death anxiety is associated with higher rates of suicide in all age groups (Ishikawa, 2020). The researcher explains suicide because of death anxiety can be a result of stopping feeling fear or regaining control over death (Ishikawa, 2020). Moreover, Worcester (2020) claims that death anxiety and its associated problems worsened because of COVID-19 restrictions because of fears of not being given a proper funeral or dying alone in a hospital. Therefore, the possible negative

outcomes of death anxiety discussed above are potentially even more likely because death anxiety can be significantly more intense due to the virus (Worcester, 2020).

Researchers have made suggestions for actions based on their research. Death anxiety is on the rise because of COVID-19, so medical personnel should recognize this potential hazard and work with mental health officials to help curb this problem, especially in the elderly (Ferreira et al., 2021). Another significant suggestion is related to religion. If the option is available, involvement in a religious institution and increasing belief in their religious teachings are negatively associated with death anxiety, meaning that lower death anxiety has been shown among those with more religious involvement (Rababa et al., 2021). Researchers recommend helping the elderly access online or radio religious congregations if the elderly person is willing, to help promote their faith (Rababa et al., 2021). Finally, Ishikawa (2020) has made suggestions specifically for mental health experts to use crisis response training because of the findings that death anxiety increases suicide rates. She recommends offering telehealth options during the pandemic to make it easier and safer for elderly clients to attend therapy (Ishikawa, 2020). She suggests therapy to encourage connectedness with friends, family, religious organizations, community organizations, etc. (Ishikawa, 2020). She also advises encouraging activities such as mindfulness exercises, exercise, routine writing, and self-care planning to emphasize feelings of control when control seems hard to find (Ishikawa, 2020). Finally, she emphasizes the importance of risk assessment as she states that suicide, elder abuse, isolation, self-care deficits, and substance abuse should be on risk assessments for elder clients (Ishikawa, 2020).

The information gained from the research about death anxiety makes it clearer that a counseling protocol for the elderly during the pandemic is needed. This chapter has presented evidence that while people of all ages have experienced death anxiety during the pandemic, elders are face the most direct threat from the disease. Counselors will benefit from empirical-based strategies to deal with this problem.

CHAPTER VI

COUNSELING TECHNIQUES USED DURING THE PANDEMIC

Chapter six focuses on how counselors are performing therapy during the COVID-19 pandemic. Counseling procedures had to be altered because of COVID-19. Protocol changes in counseling, evidence of efficaciousness of new protocols, and safety of counselors and clients during pandemics are discussed below.

The primary change discussed in the literature is the switch to telehealth and videoconferencing technology to perform therapy with clients. Banducci and Weiss (2020) found video conferencing technology to be ideal due primarily to the visual aspect of the technology. They stated that unlike therapy over the phone, video conferencing allowed counselors to view body language (Banducci & Weiss, 2020). However, Banducci and Weiss (2020) stated that not everyone has access to videoconferencing technology, so telephone therapy is required at times. Banducci and Weiss (2020) found in their practice that therapy over the phone is constructive but can be less successful than therapy with video conferencing. Krompinger et al. (2020) found telehealth useful when providing exposure and response prevention therapy to their clients. Krompinger et al. (2020) clarify that no evidence, to date, to support the use of these treatments through telehealth has been found, but state that after considering the science as a whole, they believe it highly likely that the treatment will preserve its integrity (Krompinger et al., 2020). Scientists working with the Chinese government have concluded that online and video counseling measures were useful for maintaining quarantines and expanding access to mental health services to Chinese

citizens during COVID-19 (Hu, Pan, Sun, Wang, & Mao, 2020). Psychologists in China have used these services to share common coping mechanisms and strategies to deal with psychological stress caused by COVID-19, which has helped calm the public (Hu, Pan, Sun, Wang, & Mao, 2020).

Changes other than going virtual have also been attempted. Psychiatrists providing electroconvulsive therapy (ECT) have created a plan to allow their patients to continue treatment (Burhan, Safi, Blair, & O'Reilly, 2020). Burhan et al. (2020) state that ECT is difficult to perform with patients wearing masks, so creative alternatives were required to prevent spreading COVID-19. They carefully selected patients for treatment based on the severity of their psychiatric symptoms, tested each patient before their appointment, only allowed patients with a negative test to get treatment, wore full protective personal protective equipment (PPE), and sanitized the equipment after each patient (Burhan et al., 2020). Burhan et al. (2020) also followed up with patients online that tested positive for COVID-19, despite not receiving ECT, to maintain the client-therapist relationship. These creative counseling protocol changes allowed Burhan et al. (2020) to treat patients that could not wear masks because they were under anesthesia. Weinberg et al. (2020) worked with Alzheimer's patients, and they tested their patients each time they came in so their patients could not wear masks and remain safe. Weinberg et al. (2020) also discussed how employers, institutions, sponsors, states, or federal guidelines can force change. Another change in traditional counseling protocol is represented by Robertson and Colburn in their report about changes they have experienced in their practice (2020), who have started asking questions they would never have asked their geriatric patients before COVID-19. They began asking things like,

"whom do you want to make decisions for you if you were to get sick?" and "do you have your affairs in order just in case?" (Robertson, & Colburn, 2020, p. 933). Robertson and Colburn (2020) said this change was made primarily because many of their clients have not thought of these issues until COVID-19.

Research done before COVID-19 found that video conferencing, allowing the therapist to see and hear their clients, provided comparable outcomes to in-person therapy across multiple psychiatric disorders (Matheson, Bohon, & Lock, 2020). Burhan et al. (2020) reported that they were able to restart all their most severe patients on ECT, with no new positive COVID-19 cases being reported, using the methods described above. Dorman et al. (2020) stated that, based on their opinion formed by their experience switching to telehealth options, they were confident that telehealth options provided high adherence rates for both patients and caregivers. Matheson et al. (2020) found that telehealth is a dramatic shift from traditional therapy for both therapists and clients, but the evidence shows telehealth expands access to therapy and can be as effective as in-person therapy if done correctly. van Dijk et al. (2020) found that a group of 64-70-year-old adults starting an online group therapy program had favorable outcomes in therapy. The group was able to counteract any technological problems that occurred during therapy, send homework through email, maintain therapy adherence, and receive positive feedback from the elderly clients once therapy had concluded (van Dijk et al., 2020). They found that some elders and counselors in the group held preexisting prejudices about the limited effectiveness of online psychotherapy, but the researchers found they were able to counteract those beliefs (van Dijk et al., 2020).

van Dijk et al. (2020) concluded that online therapy was viable in the geriatric mental healthcare field, but further study was required to confirm these findings.

Matheson et al. (2020) discussed in their commentary of multiple possible issues with going online. They state how some clients will have an issue finding privacy in their home for therapy, or in domestic abuse cases, therapy in the home could lead to danger for the client (Matheson et al., 2020). Matheson et al. (2020) also bring up the problem of internet connectivity, lack of technology, or lack of experience with technology. Finally, Matheson et al. (2020) state that some therapists are not competent in going virtual. These issues would need to be addressed before starting therapy (Matheson et al., 2020). In online group therapy, Matheson et al. (2020) bring up how a therapist may lose body language cues because of camera position, or clients may be less able to form meaningful relationships with people on screens (Matheson et al., 2020). Dorman et al. (2020) looked to find evidence of telehealth efficacy and found no statistically significant difference in groups of patients that received teletherapy and those that received no therapy. However, they point out the low sample size of 38 and the quick follow-up time may have affected their results (Dorman et al., 2020). Banducci and Weiss (2020) suggest that prolonged exposure (PE) may be difficult to pursue during COVID-19 because some exposure exercises, like being in crowded places, cannot be done during the pandemic. They also suggest that drug abstinence may be difficult to maintain without the ability to physically monitor these clients during the pandemic (Banducci & Weiss, 2020). The author of this thesis notes that no counseling protocol changes found in the literature to date were determined to have led to an increase in COVID-19 transmissions.

Safety during COVID-19 has been a priority, and researchers have made suggestions as to the best ways to accomplish this. Banducci and Weiss (2020) suggest the safest course of action is to be completely virtual, with no physical contact with clients. However, for those unable to go completely virtual, there are steps to keep safe. Burhan et al. (2020) wore full PPE during ECT sessions, which includes: goggles or disposable face shield, N95 facemask respirator or higher, full-body gown, and clean nonsterile or sterile gloves. Burhan et al. (2020) also created a special room that provided negative pressure and optimum air circulation. However, the CDC (2020) guidelines have stated that remaining 6 feet or more apart, wearing masks, and remaining home if feeling symptoms are adequate to prevent the spreading of COVID-19 in social situations similar to in-person therapy. Aside from PPE, some therapist have suggested, in their opinion, to consider the importance of safety plans for each client in case sessions become impossible (Ragavan, Garcia, Berger, & Miller, 2020). Ragavan et al. (2020) discuss this point from the perspective of domestic violence victims, but they also state that every client should have a safety plan during COVID-19 to help keep them stable. Ragavan et al. (2020) include in their safety plans support systems, warning signs, contacts, coping mechanisms, a physical copy mailed to the patient, a copy emailed to the patient, and reasons to live. Rhodes, Martin, Guarna, Vowles, and Allen (2020) expand on identifying support systems outside of therapy by asking about family, friends, spouses, children, grandchildren, coworkers, bosses, and social workers (Rhodes et al., 2020). If a client has none of the above, it is important to maintain contact with this client (Rhodes, Martin, Guarna, Vowles, & Allen, 2020). Robertson and Colburn (2020) add to the topic of safety plans the importance for older clients to have quick access to emergency services.

They give the example of having a necklace with a button on it that connects to 911 (Robertson & Colburn, 2020).

The information gained from the research about current counseling measures during COVID-19 can point to the need of a more generic and detailed counseling protocol for the elderly during the pandemic. Telehealth, telephone, and even heavily modified in-person sessions have been tried by counselors working with elderly clients. For the most part, based on the information above, these strategies have worked to continue counseling while stopping the spread of COVID-19.

CHAPTER VII

DEVELOPMENT OF A COUNSELING PROTOCOL FOR ELDERLY CLIENTS DURING THE COVID-19 PANDEMIC

Chapter seven will construct a generic and detailed treatment protocol for elderly populations during COVID-19 and similar pandemics. The research discussed in the previous chapters, while interesting, is not as helpful for therapists because the information is not concise. Taking this information and combining it for the goal of practical clinical application will be more helpful for therapists and clients. General treatment considerations, the treatment protocol itself, integration of the protocol into various treatment modalities, and the importance of continued research are discussed below.

General Treatment Considerations

The current research discussed below provides many general guidelines for working with elders. These guidelines are not all necessarily exclusive to any specific treatment protocol, theory, or even for working during a pandemic. However, these suggestions are fully applicable to working with elders during COVID-19 or other pandemics and should be considered.

The first major consideration is to focus time and effort on developing a strong therapeutic relationship with elderly clients. Research has determined that a strong positive therapeutic relationship decreases dropout rates in clients (Janeiro, Ribeiro, Faísca, & Lopez Miguel, 2018). Also, multiple studies have been done over the years that have concluded strong therapeutic relationships have predicted, at least partially, positive outcomes independent of other factors in therapy (Labouliere, Reyes, Shirk, & Karver, 2017; Noyce &

Simpson, 2018; Shirk, Gudmundsen, Kaplinski, & McMakin, 2008). Research has even been conducted specifically with elders, and the findings were the same; the therapeutic relationship leads to better outcomes in therapy (Mace et al., 2017).

The second consideration that is widely brought up in the literature, for multiple reasons, is the importance of providing telehealth options to elderly clients. Banducci and Weiss (2020) suggest the safest course of action, purely to prevent sickness, is for therapy during a pandemic is to be completely virtual. Ishikawa (2020) recommends offering telehealth options during the pandemic to make it easier and safer for elderly clients to attend therapy before and after the pandemic. She states telehealth is more convenient for most clients than in-person counseling (Ishikawa, 2020). The research found that when comparing video conferencing, allowing the therapist to see and hear their clients, to in person therapy, video conferencing provided comparable outcomes to in-person therapy across multiple psychiatric disorders with no statistical difference between the two groups (Matheson, Bohon, & Lock, 2020). However, researchers also suggest making sure that tech support is available to elders that have difficulty using certain technology (Eghtesadi, 2020).

Another consideration is the importance of examining personal biases or prejudices before beginning therapy. After all, research has shown age discrimination exists and is a problem for many elderly people (Dittmann, 2003; North & Fiske, 2015). Examining and reducing age discrimination can be accomplished in many ways. Stone and McMinn (2012) suggest therapists ensure the language used is not anti-elderly by becoming aware of common age discrimination words and phrases. Ayalon (2020) concluded the primary issue is portraying all older adults as one large homogenous group when discussing them. For the

topic of this thesis, therapist's bias against elderly clients should be examined specifically, but other prejudices should also be examined before working with this specific group to maintain ethical standards and proper levels of care for clients.

The final general consideration found in the literature is to try and be aware of elder client's stressors outside of therapy. While impossible to fix every stressful situation in a client's life, it is important to be aware of what may be causing their stress outside of mental problems. These stressors matter because they directly affect the client's mental health and can lead to deteriorating situations that can negatively impact their wellbeing (Ishikawa, 2020). Abuse, medical problems, age discrimination, isolation, and loneliness are stressors in elderly clients that should be monitored closely (Ishikawa, 2020).

Generic Treatment Protocol for Elders during COVID-19

The treatment protocol presented below was created to be generic and detailed. It was designed to be modified and adapted to fit any therapeutic orientation a counselor may have. The protocol should be seen as basic steps therapists can follow when working with elderly patients during COVID-19 or similar pandemics. Some steps and suggestions can be used outside the bounds of working with elders or working during a pandemic. However, they can be integrated into therapies separately if need be.

Assessing safety measures against COVID-19 should be the first step and should be completed before any clients are seen by a therapist. The therapist should determine the safety measures and policies to maintain a safe environment for the client and the therapist. Researchers make multiple suggestions. As stated above, Banducci and Weiss (2020) suggest the safest course of action for therapy during a pandemic is to be completely virtual, with no

physical contact with clients. This would prevent any possibility of spreading COVID-19 between client and counselor (Banducci & Weiss, 2020). However, some people do not have access to technology like video conferencing. If in-person counseling is required, researchers suggest full personal protective equipment (PPE) be worn by the therapist including goggles or disposable face shield, N95 facemask respirator or higher, full-body gown, and clean nonsterile or sterile gloves (Burhan et al. 2020). However, the CDC (2020) has stated that remaining 6 feet away and wearing a mask is considered best practice. Another alternative is to test clients for COVID-19 before they come in for an appointment (Burhan et al. 2020). Finally, the APA (2020) suggests updating malpractice insurance policies if none of these measures work.

Once an elderly client has begun therapy, it is important to educate them about psychotherapy. More specifically, spend time providing psychoeducation. Research has shown providing psychoeducation before and during therapy can improve therapeutic outcomes and improve client satisfaction (Bond, & Anderson, 2015; Ghafoori, Fisher, Korosteleva, & Hong, 2016). The education can include general information about the client's mental illness, information on the interventions the therapist plans on using during therapy, or information about the therapist's theoretical orientation. Once the therapist has educated the client on the interventions being used, it is important to obtain consent from the client that shows they are willing to be involved in the therapeutic process. Without explicit consent, the therapist is breaking ethical codes.

The next step is to administer preliminary assessments to better understand the elder's specific problem, and to better conceptualize the therapeutic plan moving forward. There are

a few recommended assessments that should be used with certain elders. The first is a risk assessment that includes suicide, elder abuse, isolation, self-care deficits, and substance abuse (Ishikawa, 2020). Awareness of any of these problems will inform the therapist of other assessments that should be performed as well as steps to take during treatment. Another assessment that can be administered is found in Appendix B, the Center for Epidemiological Studies Depression Scale (CES-DS). According to the APA (2018), this scale is public domain, peer-reviewed, has research backing, and has been tested across gender and cultural populations while maintaining validity and reliability. The CES-DS can be used from the age of 6 to older adults and takes 20 minutes to administer, including scoring. The use of this test is suggested since many of the problems facing the elderly cause depression. Finally, when a therapist believes a client is showing signs of an unhealthy level of death anxiety, such as excessive worrying about death or preoccupation with death, it is recommended to administer the Death Anxiety Inventory (Tomás-Sábado & Gómez-Benito, 2005). This test has been empirically supported in both English and Spanish and measures five factors that account for different areas of death anxiety. The test has been determined to have adequate face validity by eleven experts and was determined by the researchers to have proper internal consistency and stability (Tomás-Sábado & Gómez-Benito, 2005).

The next step is to create a safety plan for various problems that can arise during the pandemic, such as suicidal thoughts or medical emergencies, for each client. These are important during a pandemic because of the possibility of therapy being disrupted or the therapist not being able to be in contact with clients for extended periods. The safety plan will provide the client with ways to cope with the problems this absence might cause.

Researchers suggest including in safety plans support systems, contacts, warning signs, coping mechanisms, emergency plans, and reasons to live (Ragavan et al., 2020). A client's support system are people in the client's life that would help the client if a mental health crisis came about, while contacts are those people's phone numbers or emails (Ragavan et al., 2020). Therapists should pay specific attention to identifying support systems outside of therapy by asking about family, friends, spouses, children, grandchildren, coworkers, bosses, and social workers (Rhodes, Martin, Guarna, Vowles, & Allen, 2020). Warning signs are behaviors or thoughts clients have when their mental health starts deteriorating (Ragavan et al., 2020). Examples include isolation, increased anxiety, and hopelessness. Coping mechanisms are mental health techniques like deep breathing or journaling that the client can use when they recognize their warning sign (Ragavan et al., 2020). Emergency plans are a part of safety plans that are used when coping mechanisms and support systems fail, and the client cannot stop deteriorating mentally (Ragavan et al., 2020). These emergency plans include contact information for mental health facilities and ERs. Finally, reasons to live are included in safety plans to help keep those reasons in the front of the client's mind when in a crisis (Ragavan et al., 2020). They also suggest emailing a copy of the safety plan to the client, as well as mailing a physical copy (Ragavan et al., 2020).

After creating a safety plan, consider including community and mental health resources as well. To help reduce social isolation, one researcher suggests finding call centers manned by volunteers that will routinely contact the clients to maintain a semblance of connectedness (Jawaid, 2020). Another recommendation is providing online or safe in-person physical activities to keep elders active (Roschel et al., 2020). The inclusion of in-person

activities is debated in the research. However, most agree that as long as precautions are followed, some in-person interaction with others is a great way to get elders out of the house (Palgi et al., 2020). Finally, therapists should provide resources to help elders connect with friends, family, religious organizations, and community organizations (Ishikawa, 2020).

As stated above, this protocol is meant to be used with any theoretical orientation. With that being said, when therapists remain consistent with their selected theoretical orientations and interventions, a sense of structure is maintained for elderly clients (Jawaid, 2020). Evidence supports that elders are just as responsive to various forms of psychotherapy and psychological interventions as younger adults, specifically cognitive-behavioral, psychodynamic, and problem-solving, among other theoretical orientations (APA, 2021). However, it is important to use interventions that target belonging and self-worth, at least as part of therapy (Flett & Heisel, 2020). These interventions tend to help reduce feelings of age discrimination (Flett & Heisel, 2020).

The final step can be uncomfortable for some people but was found in the research to be important (Rababa et al., 2021). Therapists should discuss religion with elderly clients, and determine if any religious interventions are available alongside regular therapy (Rababa et al., 2021). Research has shown that involvement in a religious institution and increasing belief in their religious teachings are negatively associated with death anxiety and social isolation (Rababa et al., 2021). Researchers recommend helping the elderly access online or radio religious congregations if the elderly person is willing, to help promote their faith (Rababa et al., 2021). Encouraging connectedness with religious organizations can fight both loneliness and death anxiety concurrently (Ishikawa, 2020).

Integration of Treatment Protocol into Various Treatment Modalities

The treatment protocol shown above is generic so that it can apply to many different situations and clients. However, it is worth discussing how the protocol can be integrated into different types of therapies while maintaining its integrity.

Individual therapy is often seen as the primary type of therapy, and most research pertained to working with the elders on a one-on-one basis. Individual therapy is effective with elders and has been shown to work effectively during COVID-19 and similar pandemics in the past (APA, 2021). When working with elders individually, it is important to remember some elders will be uncomfortable with one-on-one therapy for cultural reasons (Ishikawa, 2020). An example is how some in the Latin culture believe elders should be protected for their wisdom and not be alone with strangers (Ishikawa, 2020). Also, some elders will not be as open to therapy in this style because of certain beliefs and prejudices they have against psychotherapy (Bond, & Anderson, 2015). Providing group or family therapy in these situations can be a good idea, or discussing these issues with the client before beginning therapy (Bond, & Anderson, 2015).

Group therapy is another way to work with the elderly, and this method has a large scientific backing to support its use (Yalom & Leszcz, 2021). Some articles find group therapy as effective as individual therapy, while other articles find it somewhat more effective (Yalom & Leszcz, 2021). Also, it is important to discuss the use of homogenous groups of only elders versus heterogeneous groups that contain different age groups. Groups consisting of elders only have the same advantages that other homogeneous therapy groups have (Lin, 2020). Everyone in the group is most likely suffering from similar problems, so

the conversations can pertain to everyone (Lin, 2020). Also, clients believe other members of the group are more understanding since they are sharing the same experience, so they are more likely to talk in a group (Lin, 2020). However, exposing elders to different age groups also has positive benefits. Malik (2020) found that intergenerational contact was found to have the largest effect on age discrimination, so presumably, these types of groups can lead to fewer feelings of persecution in the elderly population. Also, research shows that these types of intergenerational groups, as long as everyone in the group has the same ailment, have been found to have comparable outcomes to homogeneous groups (Lin, 2020)

Finally, the treatment protocol can be integrated into family therapy as well. Similar to heterogenous group therapy, family therapy can provide intergenerational contact that can reduce age discrimination (Malik, 2020). Furthermore, researchers made it clear that social support systems like family are important to maintaining mental health for elderly clients during pandemics (Ishikawa, 2020). The inclusion of family in any part of the therapeutic process, especially when using a family therapy, can lead to stronger social supports that can help elders (Ishikawa, 2020).

The Necessity of Continued Research

The suggestions shown above in a clinical setting have great promise to effectively improve the mental health of elderly clients during COVID-19 and similar pandemics. However, continued controlled research on the many topics related to elder mental health is necessary to develop best practices. Therapists implementing the treatment protocol proposed in the present thesis as well as researchers in the field should conduct future research to explore many of the areas of this thesis that were not as well supported as they could be with

empirical research backing. This will allow for a stronger treatment protocol in the future that will provide the most for elderly clients.

CHAPTER VIII

SUMMARY

Public health emergencies are not new for humanity. COVID-19 is one in a long history of plagues and pandemics to strike the human race. The effect it has had on the modern world is what makes this pandemic unique from others. The elderly population has faced the worst COVID-19 has to offer, as they have for various pandemics in the past. The elderly during COVID-19 have had to endure not only the disease but many other problems that have affected this population. This cocktail of problems has had dire results for this population.

According to the research above, the problems that elders experience have been made worse by COVID-19. Age discrimination has expanded as the public sees COVID-19 as a virus that only kills the elderly, which has led to further complications for the elder's health. Little to no social interaction due to self-imposed isolation out of fear or forced social isolation by governments and hospitals has led to the deterioration of elder's mental health. The death of family and friends, as well as their own mortality, has led to a rise in death anxiety in the elderly population that further harms their mental health. These issues have been researched, and solutions have been suggested.

Research into the elderly is a topic with a large assortment of information that has been collected. There are numerous articles about the elderly and their mental health going back decades. For this reason, when COVID-19 started spreading, research into the elderly and COVID-19 was started, and a relatively large volume of literature was created quickly.

However, it is hard to ignore how elder research has exploded as a “hot topic” because of COVID-19’s unique effect on that population. While this is good in the short term, the research needs to continue even after COVID-19 is under control or even gone. Research into various areas of the elderly needs to continue as this group has unique problems that need to be addressed by therapists and society as a whole. One area that has a paucity of research is the therapeutic interventions in elderly patients during the pandemic. Focusing on this aspect of research with the effects of a pandemic in the future will allow therapists to perform the most effective treatments based on empirical research, which will lead to the best outcomes for the elderly clients.

The treatment protocol provided in chapter seven of this thesis will help begin the process of switching to research-backed treatments for the elderly. However, there were a few limitations with the protocol. As this was a literature review, the research used to inform the protocol was limited to what was created by others. While not inherently a problem, some topics had to be excluded from the final protocol because no research has been written about them. Some of the articles found were not empirically supported but simply first-hand accounts from experts in the field. Ideally, these claims would be investigated and supported in the future. However, this protocol is a good steppingstone. The protocol is generic and mainly for the elders affected by the pandemic and mainly focuses on what needs to be kept in mind while working with the elderly

In sum, it is important to remember that much of the present thesis is focused on the COVID-19 pandemics. Elders experience age discrimination, social isolation, death anxiety,

depression, and abuse even when a global pandemic is not raging. This population should not be forgotten when COVID-19 is finally defeated.

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APPENDIX A

HELPFUL FORMS AND HANDOUTS

American Psychological Association. (2021). Guidelines for Psychological Practice with Older Adults. Retrieved From https://www.apa.org/practice/guidelines/older-adults

The American Psychological Association has been working to make several empirically supported guidelines for workers in the field. These guidelines have been made for various topics, but the older adult guidelines are useful for the topic of this thesis. The guidelines include how to increase competency working with older adults, knowledge about development/aging, clinical issues, assessment suggestions, and interventions.

American Psychological Association. (2020). COVID-19 and Psychological Services: How to Protect Your Patients and Your Practice. Retrieved from https://www.apaservices.org/practice/news/covid19-psychology-services-protection.pdf?_ga=2.69802518.789668083.1615322843-542450346.1615322843

This handout is not for clients, but for therapists. Specifically, those that are in control of their own practice. This handout has multiple suggestions and resources to make their practice safer during a pandemic. This was made for COVID-19, but the information is useful for similar pandemics.

American Psychological Association. (2020). Elder Abuse. Retrieved from https://www.apa.org/pi/aging/elder-abuse.pdf

This handout is designed for clients, or their loved ones, that fear they are being abused. It is also made to increase knowledge of elder abuse for therapists. The

handout contains general information and dispels some myths about elder abuse.

National Institute of Mental Health. (2019). Older adults and depression. Retrieved from https://www.nimh.nih.gov/health/publications/older-adults-and-depression/19-mh-8080-olderadultsanddepression_153371.pdf

This handout thoroughly discusses depression among elderly clients. It is published by the National Institute of Mental Health and is public domain. The handout is perfect for both elders needing more information on depression, and family/caregivers that live with the client. It covers medications, psychotherapy, emergency signs, and where to find further information.

Suicide Prevention Resource Center. (2020). Increased Access to Mental Health Care for Older Adults: Getting Support during COVID-19. *Education Development Center, Inc.* Retrieved from https://sprc.org/sites/default/files/Increased%20Access%20to%20Mental%20Health%20Care%20for%20Older%20Adults%20Final.pdf

This pamphlet is for older clients that are having trouble receiving additional mental health help. It offers suggestions about how to find mental health professionals and online resources to help in the process. This pamphlet is also useable for families of older adults that are not able to find mental health services. This pamphlet is even more helpful during a pandemic because of the harder-to-find services.

Suicide Prevention Resource Center. (2020). Promoting Psychological Health and Suicide

Prevention among Older Adults during COVID-19. *Education Development Center, Inc.* Retrieved from https://www.sprc.org/sites/default/files/Promoting%20Psychological%20Health%20and%20Suicide%20Prevention%20Among%20Older%20Adults%20During%20COVID-19_%20FINAL.pdf

This pamphlet contains important information for any client, or client's family, when suicide is discussed or suspected. Suicidal ideation or suicide attempts are an important thing to address anytime they happen in therapy. This pamphlet contains suicide facts, myths, therapies, and resources.

Suicide Prevention Resource Center. (2020). Reducing Loneliness and Social Isolation among Older Adults. *Education Development Center, Inc.* Retrieved from https://sprc.org/sites/default/files/Reducing%20Loneliness%20and%20Social%20Isolation%20Among%20Older%20Adults%20Final.pdf

This handout is primarily used to help inform and provide suggestions related to social isolation. It contains information related to loneliness and social isolation for both the client and the client's families. This handout is a part of a series of handouts specifically to reduce suicide rates in the elderly.

APPENDIX B

CENTER FOR EPIDEMIOLOGIC STUDIES DEPRESSION SCALE

Below is a Depression Inventory that can be used with elderly clients to get an accurate level of depression in the client. According to the APA (2018), this scale is peer-reviewed, has research backing, and has been tested across gender and cultural populations while maintaining validity and reliability. This test can be used from the age of 6 to older adults. It takes 20 minutes to administer, including scoring.

Center for Epidemiologic Studies Depression Scale (CES-D), NIMH

Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

	During the Past Week			
	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
1. I was bothered by things that usually don't bother me.	☐	☐	☐	☐
2. I did not feel like eating; my appetite was poor.	☐	☐	☐	☐
3. I felt that I could not shake off the blues even with help from my family or friends.	☐	☐	☐	☐

4. I felt I was just as good as other people.	☐	☐	☐	☐
5. I had trouble keeping my mind on what I was doing.	☐	☐	☐	☐
6. I felt depressed.	☐	☐	☐	☐
7. I felt that everything I did was an effort.	☐	☐	☐	☐
8. I felt hopeful about the future.	☐	☐	☐	☐
9. I thought my life had been a failure.	☐	☐	☐	☐
10. I felt fearful.	☐	☐	☐	☐
11. My sleep was restless.	☐	☐	☐	☐
12. I was happy.	☐	☐	☐	☐
13. I talked less than usual.	☐	☐	☐	☐
14. I felt lonely.	☐	☐	☐	☐
15. People were unfriendly.	☐	☐	☐	☐
16. I enjoyed life.	☐	☐	☐	☐
17. I had crying spells.	☐	☐	☐	☐
18. I felt sad.	☐	☐	☐	☐
19. I felt that people dislike me.	☐	☐	☐	☐
20. I could not get “going.”	☐	☐	☐	☐

SCORING: zero for answers in the first column, 1 for answers in the second column, 2 for answers in the third column, 3 for answers in the fourth column. The scoring of positive items is reversed. Possible range of scores is zero to 60, with the higher scores indicating the presence of more symptomatology.